University of Alberta

Peer Support and Social Determinants of Lone Mothers' Health

by

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A thesis submitted to the Faculty of Graduate Studies and Research in partial Fulfillment of the requirements for the degree of Master of Science

Centre for Health Promotion Studies

Edmonton, Alberta

Spring 2005

0-494-08156-2

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Dedication

My thesis is dedicated to my family. Accomplishing this goal would not have been possible without your support.

Abstract

Existing research demonstrates a link between social support and optimal health. More research is needed to clarify how social support exerts its influence on health. This study focuses on the social determinants of health in order to address the interactions between health and social policy in women's lives. Specifically, the affects of peer support on lone mothers' health in the context of a community support group are examined. A critical feminist perspective has been merged with grounded theory methodology in a study of 10 lone mothers. Mothers participated in interviews and data was analyzed using the constant comparative method. Findings from this study suggest that "Transcending Lone Motherhood" is the basic social process underpinning the influence of peer support on lone mothers' health. The four phases of this process include seeking stress reduction, re-establishing community, re-energizing, and moving forward. Findings from this study may help health and social services professionals develop support programs, policies, and practice styles that are more responsive to the needs of lone mothers.

Acknowledgements

I would like to acknowledge the strong, inspiring women who participated in this study. I would also like to acknowledge the work of my mentor and friend, Dr. Lynne Young.

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Chapter 1: Introduction

I came for the support of my family and my long-standing girl friends who I knew I could phone at 3 in the morning and have a place to stay…I had intended on going back to school. I knew that's what I was going to do and knew I would need a lot of support to do that…I lived with my parents initially, not really understanding how to access um… social assistance, etc., and what that (entailed) and having no income so…I didn't feel like I had a choice. The first time I separated from my husband, it was much more amicable and I was not asserting myself in any way and he was sharing his pay cheque with me. And I just accepted that. At that time, I phoned what I thought was social assistance. I found it very confusing, even to look it up in the phone book, and I was trying to access information and in hindsight, was treated abusively by the government employee that I spoke to…I feel flattened often. Absolutely everything I have to give. How do you explain that…ah…if you look at yourself as being a cup or a vessel and to be healthy that vessel is pretty full most of the time. There is a constant flow of out and in. There's more out than in as a single parent (Participant E).

Stress, poverty, and fundamental power imbalances are some of the social conditions affecting the lone mother's life in the above vignette. These social conditions often result in lone mothers experiencing higher risk of illness, injury, and death compared to mothers with partners (Benzeval, 1998; Green, 2001; Reid, 2002; Weitoft, Haglund, & Rosen, 2000; Weitoft, Haglund, Hjern & Rosen, 2002). The documented disparity in health status between lone and partnered mothers is costly. Female-headed single-parent households represent more than 1 million Canadian families and their productivity may be impeded by their social, economic, and political environment (Benzeval, 1998; Green, 2001; Statistics Canada, 2004; Wuest, Merrit-Gray, Berman, & Ford-Gilboe, 2002). Social structures and conditions interact with some lone mothers' health putting them at increased risk.

Since the introduction of the "Ottawa Charter for Health Promotion" in 1986, perspectives on women's health issues have shifted from a strict biomedical orientation to one that recognizes lifestyle factors and social conditions that contribute to women's

health status (Labonte, 1993; Wuest et al, 2002). Research is now needed to increase our understanding of the interaction between the social determinants of health and the health of specific groups of women. "Without such research, our knowledge of how social factors that underpin women's health interact will be faceless and will not address the interplay of health and social policy with women's lives" (Wuest et al, 2002, p. 795).

Health Canada's view of the determinants of health, specifically the social determinants, form the conceptual framework for this study. Each social determinant is explored in the next section including what is already known about the specific determinant and lone mothers' health.

Conceptual Framework: The Social Determinants of Lone Mothers' Health

Gender bias, poverty and inequality, personal health and coping practices, and social support have been identified as the social determinants of lone mothers' health (Reid, 2002; Wuest et al, 2002). Defining the social determinants of health and gaining insight into how they influence lone mothers' lives is the starting point to understanding the relationship between social conditions and health.

Gender bias. The influence of gender bias underpins many of the determinants of women's health (Wuest et al, 2002). Its influence is pervasive in two key ways. First, societal roles and structures have been shown to disadvantage women in the labor force (Health Canada, 1994; Ried, 2002). For example, increasing numbers of women are participating in the labor force, however a persistent wage gap between men and women has been identified in a document published by Statistics Canada:

> In 1997, women workers earned on average $15.12 per hour while male workers received $18.84. In other words, women earned about 80% of the average male hourly wage…While the wages of both men and women may increase with tenure, the gender wage gap may not necessarily decrease with tenure (Drolet, 2001, p. 9).

Research has shown that women's access to high paying, decision-making positions is restricted (Drolet, 2001; Reid, 2002). In another example, Drolet (2001) reported:

> Compared to the jobs men hold, women are less likely to be employed in jobs having supervisory responsibilities (35.2% and 24.8% respectively) and are less likely to be employed in jobs that involve budget and/or staffing decisions (21.7% and 15.7%). (p. 14).

Women typically fulfill multiple roles. This creates another barrier to their ability to obtain and/or maintain well paid full-time work. The dual roles of home/family and work exact a high price in terms of women's physical and mental health, and the strict adherence to traditional social roles (women as full-time homemakers, child, and elder-care providers) restricts women's ability to attain financial independence. (Drolet, 2001; Health Canada, 1994; Thomas, 1997; Wuest et al, 2002).

Second, the health care system perpetuates a gender bias: "Gendered norms influence the health system's practices and priorities. Many health issues are a function of gender-based social status or roles" (Health Canada, 2004, p. 1). More specifically, treatment and prevention programs for conditions that primarily affect women are poorly funded (Wuest et al, 2002). Inclusion of women in health research has been limited and medical models of women's health fall short of meeting their needs when these models

focus solely on pathophysiology and ignore women's social, emotional, and spiritual needs (Crooks, 2001; Reid, 2002; Rose, 1990; Thomas, 1997; Wuest et al., 2002). In addition, information about women's health is typically generated from large empirical studies which do not consider the contextual factors related to women's health (Reid, 2002; Rose, 1990; Wuest et al, 2002). Using an empirical or androcentric approach to understanding women's lives limits health care professionals' ability to respond effectively to women's needs (Wuest et al, 2002).

Gender bias underpins everyday experiences for many women. It is shrouded in societal norms and social structures that restrict women's potential for economic success and ultimately affords an inadequate basis for understanding and responding to women's health care needs. Broadening our understanding of the influence of gender bias in women's health requires us to consider the context of women's experiences (Reid, 2002).

Poverty and socioeconomic inequality. When limitations to economic success are considered, it is not surprising to find that lone mothers are also over-represented among the poor (Benzeval, 1998; British Columbia Bureau of Statistics, 2003; Cohen, 1994; Denton & Walters, 1999; Perez & Beaudet, 1999; Weitoft et al, 2000; Sarfati & Scott, 2001). This situation is not new and it is not likely to change in the immediate future (Caledon Institute for Social Policy, 2002; Canadian Research Institute for the Advancement of Women, 2001). For example, in 1996 there were 11,745 lone parent families in Victoria, British Columbia with an average income of $32,841(Statistics Canada, 2003). By 2001 there were 13,795 lone parent families in Victoria, but the average income had not changed appreciably over the six year period as it remained at $32,763 (Statistics Canada, 2003). In Health Canada's (1999) document "Toward a

Healthy Future: The Second Report on the Health of Canadians" Health Canada (1999) reported that 48% of female lone parent families live on low incomes compared to only 24% of male lone parent families. These statistics demonstrate that many lone mothers and their families experience poverty as a daily reality.

With poverty comes low socioeconomic status in our society (Health Canada, 1994). Social groups with low status experience a sense of powerlessness that "is demoralizing in itself and reduces the will and motivation to cope actively with problems" (Williams, 1990, p. 88). Women lag behind men on virtually every indicator of social and economic status as a reflection of the social, political, and cultural context of women's lives (Cohen, 1994; Reid, 2002). Socioeconomic inequality and a sense of powerlessness accompany poverty and affect the health status of women, like lone mothers.

Individuals with low socioeconomic status are less healthy than people in higher socioeconomic sectors, as demonstrated by several large empirical studies. This relationship is known as the "gradient effect" and it is one of the most significant findings of the 1980's (Kaplan, Pamuk, Lynch, Cohen, & Balfour, 1996; Kennedy, Kawachi, & Prothrow-Stith, 1996; Marmot, 1986; Singh & Siahpush, 2002; Wilkinson, 1996). Members of families with incomes on or below the poverty line are less healthy than those in more economically secure families and this relationship is consistent across the economic spectrum. For example, several studies have shown that poor lone mothers report lower self perceived health status compared to mothers with higher incomes (Burstrom, Diderichsen, Shouls, & Whitehead, 1999; Jayakaday & Stauffer, 2000; LeClere, Rodgers, & Peters, 1998; Perez & Beaudet, 1999; Sarfati & Scott, 2001; Young,

James & Cunningham, 2004). A number of researchers have also reported that lone mothers' financial insecurity is associated with mental health problems like depression (Baker & North, 1999; Cohen & Dekel, 2000; Jayakady & Stauffer, 2000; Schulz et al., 2001; Targosz, Bebbington, Lewis, Brugha, Jenkins, Farrell, & Meltzer, 2003).

Empirical studies have consistently demonstrated a positive relationship between the unequal distribution of wealth and poor health. Several explanations for this "gradient effect" have been suggested, including the effects of material deprivation, biological breakdown from chronic stress, unhealthy behaviors associated with stress, and decreased social cohesion (Duffy, 1986; Duffy, 1988; Jayakady & Stauffer, 2000; Kawachi & Kennedy, 1999; Middleton, 1995; Pattenden, Dolk, & Vrijheid, 1999; Sachs, Hall, & Pietrukowicz, 1995; Schulz, Parker, Israel, & Fisher, 2001). First, findings from several studies have revealed strong relationships between stress, coping, and measures of low perceived health status in lone mothers (LeClere et al, 1999; Perez & Beaudet, 1999; Schulz et al., 2001; Siahpush, Borland, & Scollo, 2002). For example, Siahpush et al's (2002) work showed that Australian lone mothers were three times more likely to use cigarette smoking as a coping mechanism than mothers with partners. Similar findings have been reported in a recent Canadian study (Young et al, 2004). Perez & Beaudet's (1999) analysis of the data collected in the 1994/95 and 1996/97 cycles of Statistics Canada's National Population Health Survey identified relationships between levels of psychological distress, economic disadvantage, and poor self perceived health status in lone mothers. Duffy (1986) found that lone mothers practiced fewer positive health-related behaviors as a result of increased stress associated with poverty and role overload.

Results from several studies demonstrate that poverty influences lone mothers' health because of increased stress and unhealthy coping behaviors.

Second, findings from other studies have demonstrated positive relationships between low social support, proxy measures of low social cohesion, and poor health status. For example, Kennedy et al (1996) conducted a national study designed to determine the relationship between income distribution and all-cause mortality in the United States. Income distribution was used as a proxy for the degree of investment in human capital. The study results indicate "less egalitarian states continued to show higher rates of homicide, both among white people and black people" (Kennedy et al, 1996, p. 1005). Singh & Siahpush (2002) compared all-cause and cardiovascular mortality to key socioeconomic conditions and found that signs of social disintegration, such as suicide, homicide, violent crime, and migration tended to be higher in areas with low socioeconomic status. Kaplan et al (1996) also demonstrated greater income inequality in geographic areas with higher unemployment, higher rates of incarceration and violence, greater dependence on social assistance, and fewer people with access to medical insurance. Low social cohesion provides an explanation for the relationship between poverty, inequality, and low perceived health status in some research.

Third, findings from other studies hold that poverty affects health as a result of material deprivation. In a grounded theory study by Sachs et al (1995), lone mothers revealed that material deprivation characterized by difficulty providing food, clothing, and shelter for their families created increased stress and diminished self esteem, negatively impacting their mental health. Travers' (1996) found that poverty, experienced as food insecurity, influenced the health of lone mothers. Although not addressed in

detail, Travers also found that mothers felt that "they were personally blamed for their failure to stretch their inadequate budgets" which may be another explanation for the link between stress and poor health (p. 550). An altered capacity to provide the essentials for everyday living has been shown to influence lone mothers' health status.

Empirical research has repeatedly shown that lone mothers are disproportionately poor, of low socioeconomic status, and experience poorer health when compared to their partnered counterparts. Prevailing explanations for this includes the negative health effects of material deprivation, physical compromise resulting from stress, unhealthy behaviors associated with stress, and decreased social cohesion. More research is needed to further elucidate the interplay between health and social policy to develop a deeper understanding of lone mothers' health and the interaction between social determinants.

Personal health and coping practices. Coping skills are the skills people use to interact effectively and to deal with events. Strong coping skills have been linked to better health outcomes because they enable self-reliance, problem solving, and promote a sense of coherence (Cohen & Dekel, 2000; Health Canada, 1994). In addition, effective coping skills have been associated with the adoption of healthy behaviors and healthy lifestyles (Duffy, 1986; Duffy, 1988; Health Canada, 1994). Healthy behavioral practices have a positive influence on health. However, Denton & Walters (1999) suggest that coping patterns are different for men and women. In addition, the interaction between coping patterns and other determinants of health, like poverty and socioeconomic status, is complex (Cohen & Dekel, 2000; Denton & Walters, 1999). Although the link between coping and health has been established, the interplay between coping and other social determinants remains unclear.

Several researchers have examined women's and lone mothers' coping skills and the impact on their well-being. However, these studies have focused on lone mothers' lack of capacity to cope. For example, Sarfati & Scott (2001) surveyed lone mothers and found that low income and unemployed lone mothers are more likely to smoke, drink alcohol, and be in poor physical condition compared to mothers with partners and higher incomes. The findings from Denton & Walters (1999), Weitoft et al (2000), and Siahpush et al, (2002) have shown significant positive relationships between lone motherhood, low socioeconomic status, and unhealthy behavior like smoking.

Qualitative studies have contributed to our understanding of the interplay between determinants of health by examining phenomena in context (Green, 2001; Morse & Richards, 2002; Morse & Field, 1995; Reid, 2002; Travers, 1996; Wuest et al, 2002). For example, Duffy (1986) found that primary prevention behaviors in female-headed families were practiced if there was a history of such practices in the mother's family of origin. Role overload, poverty, and lack of support were found to be significant barriers to the practice of healthy behavior. Sachs et al (1995) conducted a grounded theory study of poor lone mothers' coping strategies and found that stress related to an inability to provide material necessities and low self esteem caused lone mothers to seek out public assistance and develop personal resources in order to cope. Wijnberg & Weinger (1998) examined lone mothers' coping styles and found that helping women examine their coping patterns led to "reeducation and cognitive restructuring, reconnection with social resources, development of new coping behaviors and styles, and reexamination of familial and psychological impasse" (p. 218). Hertz & Ferguson (1998) conducted a grounded theory study to investigate the coping strategies of lone mothers. These

researchers found that, "women create a 'repertory family' by pulling together an ensemble of people who provide some combination of emotional and psychological support, economic contributions, and routine household chores and maintenance" (p. 26-27). Qualitative research has begun to elucidate the relationships between determinants of health. Understanding behavior from the families' perspective and consideration of the contextual milieu has the potential to lead to a deeper understanding.

Social support. The relationship between social support and health first appears in the literature in the 1980's and seems to resurge in the mid 1990's in conjunction with the study of stress and its affects on health (Duffy, 1989; Israel, 1982; Marmot, 1986; Schaefer, Coyne, & Lazarus, 1981; Turner & Marino, 1994; Woloshin, Schwartz, Tosteson, Chang, Wright, Plohman, & Fisher, 1997). Social support has been extensively studied. Therefore, chapter 2 provides a detailed review of the literature related to social support as background for the present study.

Purpose of this Study

The social determinants of health provide the conceptual framework for this study. Results from existing studies have identified gender bias, poverty and socioeconomic inequality, personal coping, and social support to be the social determinants influencing lone mothers' health.

Results from experimental research have demonstrated patterns in relationships between these determinants, and qualitative research findings have helped to explain these relationships. Further study of how the social determinants interact to influence the

health of specific groups of women are needed in order to address the interplay between health and social policy in women's lives.

The purpose of this study was to explore the interactions of the social determinants of health, specifically how social support, engendered by a peer support group, influences lone mothers' health. Consequently, an analysis of lone mothers' experiences with social support, how it interacts with other determinants of health, and how it works to influence health was undertaken. This study was guided by the following question:

> What are lone mothers' perceptions of the influence of peer support on health within the context of a community support group?

The next chapter provides a review of the social support literature in order to provide background for the study. It includes an overview of the definition of social support from an emic and etic viewpoint. What is already known about the impact of social support on health is reviewed. In addition, prevailing explanations for social support's influence on health are discussed. Some of the problems researchers encounter when they attempt to measure social support are described. Finally, social support in the context of women and lone mothers' lives is discussed to inform the present study.

Chapter 2: Background

Definition of Social Support

Since the 1980's, empirical researchers have operationalized social support as the affective, instrumental, and cognitive support experienced by individuals (Cieslak, Widerszal-Bazyl, Luszczynska-Cieslak, 2000; Stevens, 1988; Turner & Marino, 1994; Woloshin et al,1997). This definition of social support derives from a series of surveys, questionnaires, and rating scales yielding a range of theoretical constructs for perceived support over the last 15 years (Cieslak et al, 2000).

Researchers using quantitative methods define social support with specificity so that it can be measured. Qualitative researchers have characterized social support as respondents' perceptions of the experience of feeling supported under specific circumstances (Duffy, 1989; Fudge, Neufeld, & Kushner, 1997; Henderson, 1995; Landmark, Strandmark, & Wahl, 2002; Rose, Campbell, & Kub, 2000; Wijnberg & Weinger, 1998). For example, Fudge et al (1997) conducted a thematic content analysis to develop a typology of social networks for women caregivers, differentiating between types of social networks and types of received support. In another example, breast cancer survivors characterize their experience of lack of professional support using words like, "dismissed, rejected, doubt, confused, and dejected" (Landmark et al, 2002, p. 221). By using study participants' own words, a deep, contextual understanding of participants' experience with social support has been acquired.

Quantitative and qualitative methods serve different purposes and have elicited a broad range of information about social support, based on differing epistemelogical

views. Keeping both points of view in mind, the discussion now turns to theoretical perspectives of social support's impact on health.

Theoretical Perspectives on Social Support and Health

Social support has been associated with feeling well and having optimal health (Guhrer, Stansfeld, Chemali, & Shipley, 1999; Israel, 1982; Israel, Farquhar, Schulz, James, & Parker, 2002; Marmot, 1986; Schaefer et al., 1981). Empirical studies have shown that there is a direct relationship between lack of social ties and all-cause mortality and a variety of other measures of health and well-being (Dolbier & Steinhardt, 2000; Israel et al., 2002; Labonte, 1993). For example, social support has been linked to lower cardiovascular reactivity, enhanced immune function, better adjustment and recovery from illness, and improved mental health (Dolbier & Steinhardt, 2000; Hung & Chung, 2001; Schaefer et al, 1981; Targosz et al, 2003; Woloshin et al, 1997). Social support has also been associated with participation in preventative behaviors, like breast cancer screening, breastfeeding, and more nurturing parenting practices (Allen, Sorensen, Stoddard, Petersen, & Colditz, 1999; Arlotti, Cottrell, Lee, & Curtis, 1998; Ceballo & McLoyd, 2002). People who have networks of family, friends, and community are more apt to practice healthy habits and experience less disease and more optimal well-being.

It is believed that social support influences morbidity and mortality in two main ways: By buffering or moderating the negative effects of stress, and through social influence on behavior. The latter explanation is also known as the "Main Effects Model" (Allen et al, 1999).

In the Main Effects Model it is proposed that social support influences health by promoting healthy behavior through the application of social pressure to conform to behavioral norms, role modeling, and positive reinforcement (Allen et al, 1999). The model is related to Social Cognitive Theory in which it is postulated that self efficacy (a person's belief in their ability to exert control over one's life) is affected through the application of social norms, role modeling desirable behavior, and positive reinforcement (Baranowski, Perry, & Parcel, 1997). The Main Effects Model is also linked to the Theory of Reasoned Action, where it is suggested that behavior is a function of individual attitudes and subjective norms (Allen et al, 1999; Baranowski et al, 1997). Proponents of the Main Effects Model believe that the influence of the social environment reinforces an individual's desire to achieve a healthy lifestyle.

Results from several studies support this model. For example, Guhrer et al (1999) examined several aspects of social relationships and their effect on mental health. These authors found that social support within and outside the workplace increased a person's sense of control over their environment and reduced the occurrence of psychological distress. Allen et al (1999) looked at the influence of social support on breast cancer screening behavior and found that "women who believed that social network members approved of (breast cancer) screening were more likely to have a history of regular screening than women who did not share this perception" (p. 197). Some research has demonstrated that social support affects health through self efficacy, individual attitude, and the application of peer pressure to conform to social norms.

In contrast, results from three studies dispute the evidence supporting the Main Effects Model. First, Callaghan's (1998) study showed that social support was linked to

only one (fruit consumption) of 28 health-related behaviors in nurses ($r = 0.15$, $P<0.05$). In this case, social support did not influence behavior except in terms of dietary intake. Second, in a study by Dunn, Burbine, Bowers, & Tantleff-Dunn (2001) researchers inquired as to whether social support mediated stress by reducing isolation for parents of autistic children. The results indicated that "there was no direct relationship between social support and isolation" (p. 48). These findings suggest that some of these parents experienced the stress of isolation despite receiving social support. Third, Hung & Chung (2001) found that, compared to Western mothers, postpartum mothers in Taiwan have a lower incidence of postpartum depression despite the traditional Taiwanese practice of isolating mothers at home for one month after delivery. The lack of social support from friends and community did not seem to influence these mothers' mental health in terms of post partum depression. In contrast to findings that support the Main Effects Model, the findings from these three studies do not support the idea that social support influences health by promoting healthy behavior which may suggest that there are other factors to be considered.

Social support may also affect health by buffering or diminishing the negative effects of stress (Allen et al, 1999; Duffy, 1986; Guhrer et al 1999; Rose et al, 2000). It may bolster an individual's emotions to alter the appraisal of threatening events and it may have a physiological effect such as altering blood pressure, serum lipids, immune system functioning, or stress hormone release (LeClere et al, 1998; Sarfati & Scott, 2001). For example, Katerndahl & Parchman (2002) tested the Stress Process Model and found that social support was a personal resource that moderated stress and improved mental health outcomes. Ceballo & McLoyd (2002) found that social support was

associated with nurturing parenting strategies despite the stress of living in poor, dangerous neighborhoods. Hanna, Edgecomb, Jackson, & Newman (2002) studied the effects of parent support groups on parenting and found that social support dissipates some of the stress associated with early parenting. Many recent studies have demonstrated that the negative effects of stress can be diminished by social support.

On the other hand, results from several studies contradict these findings. For example, one noteworthy study by Israel et al (2002) examined "the effects of stress, social support, and health over and above the effects of age, income, education, and marital status" (p. 345). The researchers surveyed a random sample of 700 mostly African American women for sources of chronic stress, degree of stress, frequency of self-perceived emotional and instrumental support, depressive symptoms, and general health. Data were analyzed using a series of regression models to examine the relationships between variables. Results indicated that the women experienced high levels of financial, family, and police-related stress having a significant direct effect by increasing depressive symptoms. Results also indicated that initially, the impact of instrumental support on general health and depressive symptoms was significant, but over time "the analyses of the interaction effects between each of the types of social support and each of the stress variables did not result in more statistically significant interactions than would be expected by chance" (Israel et al, 2002, p. 352). The study by Cieslak et al (2000) examined the effects of social support on stress in a sample of 200 Polish women employed as clerks. Results were mixed. Some, but not all indexes of social support were an important source of variance of well-being indexes. In addition, the authors found:

> Where it was expected that a buffering effect would take place, the obtained results indicated quite an opposite effect: Persons with a high level of stressors and a high level of emotional or practical support from supervisors had a higher level of anger as a trait than persons with a high level of stressors but a low level in the area of the mentioned support indexes (p. 288).

The two studies by Cieslak et al (2000) and Israel et al (2002) demonstrate that the stress buffering effects of social support have not been consistently established, therefore further research is needed to explain how social support influences health.

This contradiction may exist because of the inherent difficulties in quantifying complex concepts and relationships, like those associated with social support. In the case of stress and social support for example, the effects of individual variables can be difficult to isolate because people with low levels of social support are also likely to be people who experience severe stress associated with loss, as in the case of death or divorce (Schaefer et al, 1981). In addition, different measures of social support or different analytic strategies might result in different findings (Israel et al, 2002). There is some evidence that social support reduces morbidity and mortality. Some researchers believe that there are direct effects through the maintenance of social practices and mores. Others support the view that social support effects health by mediating the stress process. Both perspectives have been tested, yet conflicting results that do and do not support current explanations of the relationship between social support and health indicate that further research is needed to clarify *how* the relationship works.

Social Support for Women and Lone Mothers

Several studies noted gender-related differences in perceived social support (Guhrer et al, 1999; Turner & Marino, 1994). For example, Turner & Marino (1994) documented patterns in the social distribution of perceived support. They found that unmarried women tend to experience higher levels of perceived support than unmarried men. Guhrer et al (1999) also studied gender differences in perceived support and found that women tend to mobilize support better and are better at developing new sources of support than men. In addition, the study found that men typically confide in their spouse, whereas women typically confide in other women. Some research has compared perceived social support in men and women and found that there are gender-related differences in the supportive experience.

Researchers have also examined the nature of reciprocity in women's supportive relationships (Duffy, 1989; Guhrer et al, 1999; Henderson, 1995; Harrison, Neufeld, & Kushner, 1995; Thomas, 1997). For example, in Duffy's (1989) study female participants indicated that an opportunity to provide support was as important as receiving support because it helped to establish equity in their relationships. Henderson (1995) also explored the dynamics of reciprocity and found that women were eager to provide support concurrent with receiving support because "working on other peoples' emotional well-being had the effect of boosting their own" (p. 124). Some studies have found reciprocal relationships to be beneficial.

However, Henderson (1995) also found that there may be an implicit health risk in the exchange of peer-provided support because:

> ...The identified recipient is, by definition, likely to be in a fragile emotional state, and, therefore, to have entered the interaction in a less favorable negotiating position. The identified support provider is both untrained to recognize the effect of one person's behavior on another and driven to meet her own needs because of her vulnerability (p. 125).

Guhrer et al (1999) also points out the potential for "spillover effects of others' adversity" (p. 84). In other words, women may become over-burdened by the obligation to provide support to others. While some studies demonstrate the importance of reciprocity in women's supportive relationships, others identify potential negative effects of having to give and receive support at the same time.

Social support for lone mothers has been explored in several studies. Some scholars suggest that lone mothers are more isolated and lonely compared to mothers with partners. For example, Sarfatti & Scott (2001), and Targosz et al (2003) suggested that lone mothers had a higher risk of psychological stress due to social isolation. On the other hand, several researchers have investigated lone mothers' existing supportive relationships. For example, both Harrison et al (1995), and Schulz et al (2001) reported similar findings. Harrison et al (1995) found that lone mothers experience support from other mothers who have had similar experiences. These authors stated, "the women preferred support that came from individuals in the inner circle who they viewed as sharing commitment, history, and close emotional ties" (p. 860). Sachs et al (1995) also studied the characteristics of lone mothers' social networks and found that family relationships are often associated with conflict, however family members may be

supportive in child rearing. This finding has also been supported in the works of Harrison et al (1995), and Schulz et al (2001).

Other researchers have focused on the personal qualities lone mothers seek in their support person. For example, Duffy (1989) found that lone mothers look for loving, understanding confidantes who are trustworthy and share similar values. Lone mothers may consider people to be supportive if they will listen, explore ideas, and allow them to make their own decisions (Harrison et al, 1995; Rose et al, 2000). Relationship continuity and reciprocity have also been found to be important for lone mothers because they do not want to feel as though they are a burden to others (Duffy, 1989; Harrison et al, 1995). Although lone motherhood has been associated with social isolation, this may not always be the case as some researchers have demonstrated that lone mothers seek out support from family and close friends.

- *Measuring Social Support*

The links between social support and health have been well established by empirical research (Dolbier & Steinhardt, 2000; Hung & Chung, 2001; Schaefer et al, 1981; Targosz et al, 2003; Woloshin et al, 1997). However, the nature of the relationship is still not well understood (Allen et al, 1999; Katerndahl & Parchman, 2002; Landmark et al, 2002; Nyamathi, Bennett, Leake, & Chen, 1995; Thomas, 1997). Lack of a consistent definition for social support is part of the problem. Historically, there has been a notable difference in how social support is conceptualized (Dolbier & Steinhardt, 2000). The terms "social support" and "social networks" have been used interchangeably. Social networks are the number of social contacts, not necessarily the quality of the

supportive experience (Schaefer et al, 1985). Using a consistent definition of social support may help to resolve some of the problems associated with measuring supportive experiences.

Reliable measures of social support pose another problem. According to Dolbier & Steinhardt (2000), epidemiologists typically measure social support as received support, while researchers with a psychology background typically measure social support as perceived support. Cieslak et al (2000) are of the opinion that the measure of perceived support is gaining favor among scientists because it can be conceptualized as a continuum. However, other studies demonstrate the risk in using perceived support as a measure of social support. For example, perceived support may be moderated by personality factors or distorted by the presence of depression, as shown in the studies by Dunn et al (2001), Landmark et al (2002), and Targosz et al (2003). Landmark et al (2000) demonstrated the influence of the environment on the subjective measure of social support. A study by Ceballo & McLoyd (2002) showed that the receipt of social support was modified by neighborhood quality. Defining and measuring social support consistently across disciplines remains problematic because the effects of other variables are difficult to separate from social support.

Sampling presents another challenge for researchers. Homogenous samples like cohorts have been used in an effort to improve construct validity. However if cohorts are used, study results cannot be generalized to different groups in the population. For example, in Cieslak et al (2000) the sample represented a cohort of Polish female clerks who all lived and worked in one city and therefore, the sample is not representative of women in general. Also, Guhrer et al (1999) sampled an occupational cohort of civil

servants which may have been non-representative of a broader population of women. Sometimes the problem of non-representative samples is due to low survey participation rates, as in the case of Callaghan (1998); and Woloshin et al (1997). Qualitative findings are also inherently limited in their applicability to general populations because the findings represent the experiences of a particular group of people in specific context. However, naturalistic researchers consider the transferability of findings rather than the generalizability, in keeping with their epistemological view of multiple, socially constructed realities (Seale, 1999). Homogenous study samples help to ensure validity, however non-representative samples also limit researchers' ability to generalize results to a broader population.

Qualitative findings may or may not be transferable to a broader population, but the complexities of social support can be captured in a holistic way using participants' own words to illustrate beliefs, stories, and personal experiences (Creswell, 1998). For example, Henderson (1995) used a phenomenological approach to increase our understanding of abused women's experiences of peer-provided social support. Although previous studies were unable to demonstrate reciprocity in supportive relationships, Henderson found that giving and receiving support occurred concurrently in this group of women. Wijnberg & Weinger (1998) employed grounded theory to explore the role of social networks in poor lone mother's lives. These researchers studied subsets of lone mothers in order to reflect individual differences in the supportive experience. Based on these findings, they developed a range of recommendations to meet the needs of various women. Qualitative methods are useful in the study of complex human interactions like

social support because they afford the opportunity to understand social processes holistically and contextually.

Social support is challenging to measure because a consistent, cross-disciplinary definition remains unresolved. There is potential for social support to be confounded by other variables and applicability of study findings to the general population may be limited by the use of non-representative samples. However, scientific researchers have been able to establish a relationship between social support and health, and qualitative researchers have been able to capture the complexities of social support in a holistic and contextual way.

Summary of Social Support Literature

Research from the 1980's consistently demonstrates an important link between social support and optimal health. More recently, research has focused on the effects of social support on specific vulnerable population groups, like poor women and lone mothers. However, there are inconsistencies in the literature. On one hand, lone mothers have been found to be socially isolated; an explanation for higher morbidity and mortality in this group. On the other hand, several studies have documented trends in lone mothers' social support group characteristics. More research into lone mothers' experience of social support is needed to disentangle conflicting findings.

Two explanations for the relationship between social support and health prevail. Some researchers support The Main Effects Model in which it is postulated that health is affected through social conventions. Other researchers suggest that social support

diminishes the negative effects of stress, thereby improving health. More research is needed to fully explain how social support affects health.

The study of social support poses significant challenges. Scientific studies have difficulty capturing the complexity of human relationships into a set of distinct, measurable variables. Non-representative samples limit researchers' ability to generalize findings to the broader population. Balancing the need for internal and external validity creates a significant challenge for researchers studying social support. Qualitative studies inquire into the nature of social support inductively. Social support is characterized as respondents' perceptions of the experience of feeling supported under specific circumstances. Despite criticism for lack of rigor, qualitative researchers believe methodologies like phenomenology and grounded theory permit the researcher to attend to the underlying social processes and capture the complexities of social support in a more holistic way. Qualitative and quantitative research methods serve different purposes and have elicited different types of valuable information about social support and its influence on health.

The Present Study

A review of existing literature on lone mothers' health and social support has highlighted the need to explain the relationship between social support and health, and the need to illuminate the interaction of social determinants and health in specific groups of women. As a result, an inquiry into the interaction of the social determinants of health and the impact of social support on lone mothers' health was completed and is reported in the following chapters.

Chapter 3: Methods and Procedures

The Research Strategy

The purpose of this study was to explore the interactions of the social determinants of health and specifically explicate how social support, engendered by a peer support group, influences lone mothers' health. Grounded theory was chosen as the method for this study. I believe grounded theory is compatible with a constructivist philosophical view, it can be merged with a critical feminist perspective preferred in the study of women's issues, and it contributes to further the development of theory needed to understand how social support influences lone mothers' health.

First, this research was based on a constructivist philosophy because as the researcher, I assume that reality is constructed through social interactions; lived experience in socio-historical context (Labonte & Robertson, 1996). Assuming a constructivist perspective afforded a broader understanding of the study participants' experiences of lone motherhood in social, political, and economic context.

I believe that grounded theorists can assume a constructivist perspective because in grounded theory, the interactive inquiry process affords an opportunity for the participant to reconstruct her reality through discourse (Labonte & Robertson, 1996). Based on symbolic interaction, grounded theorists derive meaning by interpreting symbols (language) used to explain human action (Schreiber & Stern, 2001). Through the use of dialogue, grounded theory focuses on a process or trajectory which embodies the action of participants and explains the dominant social and structural processes affecting individuals' health experiences (Morse & Field, 1995; Wuest et al, 2002). For example, the semi-structured interview provided a forum for participants to discuss their

experiences of lone motherhood. They spoke about the social, economic, and political factors influencing their lives. Through the inquiry process, a dialogue was established to identify the social factors that influenced participants' lives and through the course of dialogue, the relationship between peer support and lone mothers' health was clarified.

Second, grounded theory was well suited to this investigation because the process of analysis required that I deconstruct and reconstruct the discourse around the experiences of lone motherhood, illuminating the interaction of the social determinants of health and the social processes underpinning the relationship between social support and health (Keddy, Sims, & Stern, 1996; Wijnberg & Weinger, 1998). For example, I divided the data into incidents for comparison. I categorized concepts, patterns, and properties until a core concept emerged to explain the process underpinning the relationship between peer support and lone mothers' health. Grounded theory provided a systematic procedure for exploring the basic social process at the root of lone mothers' supportive relationships.

Third, I believe that grounded theory can be merged with a critical feminist perspective (Keddy et al, 1996). Critical theorists contend that social structure and human agency are mutually interdependent and that an issue is best understood from the perspective of those most affected by it (Schreiber & Stern, 2001). The major tenets of a feminist perspective in research include acknowledging the oppressive nature of social structures in women's lives, incorporating reflexivity and reciprocity into the research process, validating the dialectical nature of the researcher-participant relationship, and recognizing the potential for research to be transformative (Keddy et al, 1996; King 1994; Kushner & Morrow, 2003; MacDonald & Schreiber, 2001; Wuest et al, 2002).

Some researchers have explored merging grounded theory with a critical feminist perspective. For example, Wuest et al (2002) used grounded theory to elucidate the social determinants of women's health. Wuest et al (2002) stated, "grounded theory is useful for policy research because the research process contributes to shaping services in minor ways and raising consciousness among policymakers regarding how their work plays out in women's everyday lives" (p. 806). Wijnberg & Weinger (1998) conducted a grounded theory study of social support systems for poor lone mothers and used findings to advocate for changes to social work practice and policy development. Although controversial, some researchers believe that grounded theory can be successfully merged with a critical feminist perspective.

By using grounded theory in this study, the depth and breadth of the women's issues were explored by understanding how meaning was constructed through the use of language. For example, the questioning technique used in the interview provided participants with a forum to reflect and deepen their understanding of their issues in the context of social structures and conditions (Benoliel, 2001; King, 1994). The study findings were grounded in the participants' own words so that their issues were understood from their point of view. Reciprocity was incorporated into the research process during the interview while participants recounted their journey through lone motherhood with emotion. I provided emotional support to the participants and shared details of my own personal journey through lone motherhood. Participants seemed to appreciate my openness as indicated by their improved ability to maintain eye contact and coherently tell their story. Opportunities for social change were created by sharing the study findings with the lone mothers and supporting their endeavor to present the

findings at the next International Family Nursing Conference in Vancouver. A critical feminist perspective was merged with grounded theory in this study by incorporating reflexivity and reciprocity into the research process, by viewing the problem from the participants' perspective, by validating the dialectical nature of the researcher-participant relationship, and by supporting an opportunity for the participants to disseminate the study findings to promote social change.

Blending a critical and feminist perspective with grounded theory is not without some tension, however. Gender bias is not necessarily a primary concern for critical theorists or grounded theorists, whereas it is for feminist researchers (Schreiber & Stern, 2001). Critical theorists typically emphasize rationality over subjectivity, in contrast to feminist researchers who focus on women's subjective experiences (Keddy et al, 1996; King 1994; Kushner & Morrow, 2003). Power inequities are sometimes maintained within a critical theorist's and/or a grounded theorist's research team, however feminist researchers contend that relationships should be non-hierarchal (Schreiber & Stern, 2001). Merging a critical and feminist perspective with grounded theory is challenging, but made possible by attending to women's subjective experiences, issues of relational power, and gender bias.

Grounded theory method has evolved since its inception in 1967 (Glaser & Strauss, 1967). While data analysis was once considered a strict linear process, researchers now conceive of the back-and-forth between data collection and analysis to be a more cyclical exercise (Benoliel, 2001). MacDonald & Schrieber (2001) consider grounded theory to have evolved from its original modern conception to a post-modern philosophy because it is primarily concerned with meanings constructed and

reconstructed in light of peoples' living circumstances. Researchers have adapted the process to incorporate feminist views and participatory approaches (Kushner & Morrow, 2003; Weust et al, 2002). Grounded theory was an appropriate method for this study because it fits with my constructivist philosophical view, it merged with a critical feminist perspective, and it contributes to the development of theory needed to understand how social support operates to influence lone mothers' health.

Sample

A theoretical sample of ten lone mothers was drawn from a local community support group. Sampling was done strategically based on what each respondent revealed about her experience in order to achieve maximum variation in the data. Sampling criteria was purposely chosen to maximize variation in age, number and age of children, living conditions, and experience with the support group. Also incorporated in the sample were three lone mothers who were not strongly connected to the support group in order to cover a wide range of perspectives. The final sample was based on the length of time in the field needed to uncover the participants' salient issues and reach saturation (Mertens, 1998; Olshansky, 1996). A table of demographic data is included in Chapter 4.

Recruitment and Setting

After receiving ethical approval from the University of Alberta (February 2, 2004), the facilitator/host of a community support project recruited volunteers to participate in the study. The first names and telephone numbers of volunteers were given to the researcher who proceeded to contact potential participants by phone to provide a

detailed explanation of the study and answer questions. After two unsuccessful attempts to contact volunteers by leaving telephone messages, the researcher moved on and attempted to contact the next volunteer on the list. After successfully contacting an interested volunteer, a convenient date and location for the interview was mutually agreed upon. Participants were also provided with a list of free counseling services available in the community to assist participants with any issues potentially arising from the interview.

Data Collection

After obtaining informed, written consent (Appendix A and B), demographic data was collected, an interview was conducted, audiotaped, and later transcribed verbatim. All personal identifiers were removed from the transcripts in order to maintain confidentiality. A copy of the transcript was provided to each participant to review for accuracy. Each respondent was contacted two weeks after the interview to see if they had any additional information to add.

Semi-structured questions guided the interviews. The interview guide was pilot-tested with one mother. A sample of the interview guide is provided in Appendix C. Initial interviews ranged from 1-2 hours in length. Interviews were conducted in concert with data analysis. This back-and-forth between data and analysis was necessary for the development of theory. Four of the mothers participated in a second interview in order to clarify some of their previous comments and provide more in-depth information to help develop theory.

Concepts explored in the interviews were related to the issues uncovered in the literature review and issues brought forward by early study participants. For example, upon analysis of the first participants' interviews, information about their sense of connection to the single mothers' group was identified. Questions relating to this sense of connection were added to later interviews in order to clarify and elicit as much information as possible about the concept. Collecting the data continued in this back-and-forth fashion until no new concepts or properties of concepts emerged from the interviews.

Data Analysis and Interpretation

After transcribing the data, NVivo computer software was used to simplify storage, retrieval, and coding. Data were analyzed using the constant comparative method described by Glaser & Strauss (1967). Initially, open coding was used to categorize the data (Benoliel, 1996; Glaser, 1992; Strauss & Corbin, 1994). Next, the data were unitized (divided into incidents for comparison). The units were grouped according to similarities. In-vivo language was used to name the resulting themes (Strauss & Corbin, 1994). This process continued until saturation occurred and a core theme or category emerged (Glaser, 1992; Olshansky, 1996).

Analytic and reflective memos were an invaluable way to record budding ideas and insights related to the data (Glaser, 1992). In order to understand the participants' experiences, I had to reflect on my personal experience and the participant's experience in the context of the symbolic meanings of these situations and their effect on the women's action and interactions (King, 1994; Kushner & Morrow, 2003; Olsen, 1994).

The nature of this investigator – participant relationship was reflexive and befits a feminist perspective (Benoliel, 2001; Kushner & Morrow, 2003). According to King (1994), "it is through women's own experience and especially through their life crises, that they are able to view and understand the world around them. Such reflexivity allows women to truly understand gender asymmetry and the plight of marginalized people" (p. 20). Although my personal experiences with lone motherhood were brought into the research experience, periodic checks with Dr. Lynne Young were conducted to discuss these personal feelings and minimize researcher bias in the interpretation of findings. Memos documented and enriched the analytic process by making implicit thoughts explicit (Creswell, 1998). A detailed written account of sampling decisions provided an audit trail. Use of memos and checks with the research supervisor were techniques that were used to ensure accuracy of findings.

Selective coding (connecting the categories to build a "story") required negotiation to articulate links between categories (Creswell, 1998). It was helpful to briefly step back from the data to reflect. I found it challenging to view the data as a whole while simultaneously considering the sum of its parts. Creating a visual representation of the core category assisted the conceptual process. This step required intuition, creative expression of ideas, and reflection on past personal and professional knowledge and experience; also known as theoretical sensitivity (Strauss & Corbin, 1994).

Finally, the basic social process underlying the concept of peer support for lone mothers was identified and articulated. Concepts were related to each other and existing

research was utilized for comparison purposes. A diagram depicting the analysis procedure is provided in Figure 1.0:

Figure 1.0 The constant comparative method of data analysis adapted from Glaser & Strauss (1967).

1. Raw Data Collected in semi-structured interviews.

2. Open Coding
Broke down data into incidents;
Compared incidents for similarities and differences;
Asked "what category or property of a category does this incident indicate?"
Coded as "free" codes.

3. Substantive coding used to generate categories.
Emerged concepts and properties of a concept and patterns of incidents;
Used in vivo language to name categories.
Coded as "trees".
Continued until saturation and a core category emerged.

4. Used selective coding to relate concepts to each other to build a conceptual model.
Identified basic social process.
Compared to existing theory.

5. Substantive theory developed.

Summary

Grounded theory methodology was used in this research study. A theoretical sampling technique was employed which is consistent with grounded theory methodology. Lone mothers were drawn from a local peer support program hosted by a community agency. After an informed consent procedure, lone mothers were invited to participate in semi-structured interviews in order to collect data about peer support, lone motherhood, and health. The data were analyzed using Glaser & Strauss' (1967) constant comparative method, which required a back-and-forth interaction between data collection and analysis. Specific techniques like the use of in-vivo codes and detailed field notes and memos helped to ensure trustworthy analysis. Themes emerged from the data, were compared to existing literature, and new substantive theory developed to explain lone mothers' perceptions of the interaction of the determinants of health and the influence of peer support on health within the context of their community support group.

Chapter 4: The Findings

Chapter 4 reports the study findings including information about how the mothers define health and their beliefs about the impact of lone motherhood on their health. The findings also present the participants' perceptions of how their health is affected by membership in a local support group. Pseudonyms have been used to protect the confidentiality of the participants. First however, the participants' demographics are presented in order to provide a snapshot of the sample characteristics.

Demographics

A total of ten women participated in this study. Four were interviewed twice to clarify comments and explore ideas from the first interview. Participants' ages ranged from 24 years to 37 years, with the average age being 29 years at the time of the interview. The ages of the participants' children ranged from 14 months to 5 years. Participants had been single parents for an average of 2.7 years. Six of the women were considered to have been in common-law relationships with their partners, one woman was legally married, and three mothers were single. The majority of the participants each had one child, one participant had two children; seven of the participants indicated that their pregnancies were unplanned.

There were two noteworthy differences in demographic patterns: Three participants had recently re-partnered, however they still considered themselves to be lone mothers because they assumed sole responsibility for parenting; and three of the women had significantly higher income levels than the majority of the participants,

reflecting the difference between being dependent on social assistance and receiving a wage.

In terms of the overall economic picture, seven of the participants had received social assistance benefits during their pregnancy or for some time throughout their child's life. The other three participants earned a wage. Eight of the participants were employed, seeking employment or making the transition to employment through additional education. Demographics are summarized in Table 1.0.

Health Defined as a "Sense of Balance"

In response to the question, "how do you define health?" participants consistently defined health as a sense of balance. The physical, mental, emotional, and spiritual aspects of health were considered to be interrelated. One participant said:

> My definition of health is much more than just sort of physically being healthy, you know all the organs and the systems working. I think emotionally it's a big thing as well - emotionally, physically, spiritually, um…and just sort of being…having all those work together to create a healthy being. (Mom 6).

Another participants said, "I think if you kind of have one area where your needs aren't getting met or where you're not doing well, then it affects all of you" (Mom 9). Some described it as a feeling of being centered or "grounded in reality" (Mom 5, Mom 8, Mom 9). Consistently, participants reported that health is the inter-relationship of the physical, mental, emotional, and spiritual aspects of well-being.

Participants placed particular emphasis on their desire to feel a sense of happiness and its perceived physical affects on the body. Mom 4 used an interesting metaphor to

Table 1.0

Demographic Data

	Mom 1	Mom 2	Mom 3	Mom 4	Mom 5	Mom 6	Mom 7	Mom 8	Mom 9	Mom 10
Mother's Age	31	29	26	27	37	31	37	26	26	24
No. of children	1	2	1	1	1	1	1	1	1	1
Child's Age	1	5 and 2	8	3	4	2	5	3	5	2.5
Pregnancy Planned	Yes	Yes	No	No	Yes	No	No	No	No	No
Employed	Yes	No	No	No	No	Yes	Yes	No	No	No
Student	No	Yes	No	No	Yes	No	No	Yes	No	Yes
Received Social Assistance	No	Yes	Yes	Yes	Yes	No	Yes	No	Yes	Yes
Past Marital Status	CL	CL	Single	CL	Married	CL	CL	CL	Single	Single
Length of Time as Lone Mother (yrs)	1	1.5	8	2	4	0.5	3	2	3	2
New Partner	Yes	No	No	Yes	No	No	Yes	Yes	No	No

Note. CL = common law

make her point, "I think your emotional and intellectual stuff grows from the bottom up, kind of like a tree, right? So if you roots are in crappy soil you're not gonna reach your branches high enough". Mom 4 linked emotional and intellectual health to physical health. Another participant provided a similar example when she spoke about how interactions with social services employees have the potential to influence her self esteem and affect her "core" well-being.

Several participants also linked physical health to healthy behavioral practices, like getting adequate rest and eating a balanced diet. They also linked physical well-being to an emotional and spiritual sense of "being strong". For example one participant said, "I've always had to keep active and have a balanced diet, which are (two) things that I think consciously, daily I work on. I think for myself, those things help me feel strong, be strong" (Mom 8). Participants felt that looking after ones' physical health by adopting healthy habits was considered to be important for core strength.

Participants emphasized the importance of the relationship between mental, physical, emotional, and spiritual needs in their definition of health. They understood health to be a sense of balance.

The Interaction of the Social Determinants of Lone Mothers' Health

Poverty, inequality, and the disadvantage of gender bias interfaced to exact a toll on the participants' ability to cope. Participants were very clear about their belief that the social welfare system does not provide financial support to meet their families' basic needs. For example, this mother's words painted a clear picture of her situation:

> The stresses of poverty, knowing there is mould growing on your walls all winter, oh, this bill comes and you're looking for a job but you don't have time to apply for it because you just fell asleep on your face with your kid when you were trying to put them to bed…and you wake up the next morning and like oh, shit there are people coming after you like you're a criminal because you're on welfare…it's crazy. My heart's just ta-da-da-da (Mom 4).

In the following quote, Mom 4 spoke of the seemingly heartbreaking choice that she regularly had to make as the primary family decision-maker - pay for housing or purchase food:

> I receive $845 (in total) from welfare. They give you $520 shelter allowance, that's the maximum shelter allowance with one child and this place is $560 plus utilities…so, like it's enough money that I pulled it out of whatever your supposed to be eating on to live which is pretty typical.

Mom 4 had to choose between paying for housing or purchasing food and this situation has become the norm for her over time. One of the realities for mothers who subsist on welfare is that the money they receive doesn't meet the basic needs of family members.

All of the participants in this sample who came into contact with the social welfare system were able to provide vivid examples of injurious encounters. For example, Mom 5 explains:

> So when I went to social assistance, I was abused there, too. I remember sitting in the initial meeting. They give you a handout and you have to come in and they have a flip chart that has all the pages of the handout on it and they lead you through it all. I've filled the thing out, I've taken it home, I've had it for a week

and a half, and then I had to come back and sit there for an hour and a half to two hours in this little room with a whole bunch of other people with this snotty 25 year old man at the front of the room. And two things happened: My son had to come with me, it's a single parent office, I can imagine it happens sometimes. You're in crisis, trying to find child care while in crisis, or even…. at that time, I held him close. He was young and I kept him close to me…my barometer was on overload because his Dad was coming back from Alberta and I didn't know if he was going to take him or what was going to happen. So accessing child care wasn't that easy in a new place. And my son had to go to the bathroom, and he needed a drink of water. So I'm sitting at this table and I said, "Excuse me, but I need to excuse myself and take my son to the bathroom." And so they have this huge, slamming, prison-like locking door between the waiting room and the "back forty" where they take people for these meetings. And so I said, "Would it be a problem to come back in?" because I knew the door locked. And he said, "I hope not." And I thought, Okay. And there was definite energy and intention with his statement. Definite intention. Then the next thing…was (my son) needed a drink of water…which probably led to him needing to go to the bathroom…So I asked if we could get a drink of water and he said, "No, we don't have water." And me, I'm lippy, right? And I said, "Okay, so you're telling me in this entire office, no one drinks water?" And he stood there for a minute and he got huffy and he put his thing down and said, "Fine, just a minute," and he went out and got him a drink of water…and so I had interrupted this guy three times and he was getting pissed off…I walked out feeling "Shit! I'm a bad mom - I didn't make sure my kid

> went to the bathroom, had enough to drink, didn't pack Kleenex. Part of me felt that and the other part of me was just damn mad!

Mom 5 perceived her experiences with the social services system to be injurious to her mental and emotional health. This experience influenced her perception of herself as a "bad" mother originated. Her story also provides an example of how the interrelated social structures and conditions (poverty, stress, parenting responsibilities, and role expectations of a "good" mother) play out in lone mothers' day to day lives. Many of the participants in this study had similar stories. They used words and phrases like, "powerless" (Mom 2) "inflexible" (Mom 9), "lacking compassion" (Mom 9), and "abused power" (Mom 5) to describe their interactions with a system that is supposed to be supportive to people in crisis.

Participants who were not dependent on social assistance also experienced the stress of having to provide for a family on a reduced household income:

> Financially I don't think it matters how much money you got, financially it still is difficult having like one income, no matter how high your income is, even if you're a millionaire, one income is much less than two. And two households, you know, cost more than one (Mom 6).

All of the participants reported a limited capacity to meet basic needs due to a reduced income after separating from their partners. Having limited capacity to provide material necessities for their families had an enormous impact on lone mothers' health.

Fatigue, for many of the participants, was associated with assuming multiple roles. One participant said, "I can remember being so tired and not from anything

physically that I was doing but kind of emotionally and mentally just wiped at the end of the day and thinking oh my god, like this was a doozy" (Mom 7). Another stated:

> Last night I lost it on her…and I hadn't seen her all weekend. I should've been more than happy to just sit on the floor and play for 3 hours but I couldn't do it. The house was a mess and I wanted to clean, I had a paper to finish….I had all these things that are my little world, right, that you can't ever part with to be a Mom. You can't just put them out of your head to like be there with your child (Mom 4).

Mom 5 provided another powerful example:

> I feel flattened often. Absolutely everything I have to give. How do you explain that…ah…if you look at yourself as being a cup or a vessel, and to be healthy that vessel is pretty full most of the time; there is a constant flow of out and in. There's more out than in as a single parent.

The multiple demands of motherhood depleted participants' personal energy resources, exacerbating their stress level and compromising their health.

Many of the participants confided that they were lonely and felt isolated and "quarantined and absolutely not invited to that nuclear family happiness thing" (Mom 4). The women used other powerful phrases like "being a prisoner in your own home" (Mom 5) and "I was an island" (Mom 7) to describe their sense of loneliness and isolation. One participant said, "I think…there was a good six month period that I wished that I had (my married friend's) life, but I didn't. Or I was thinking to myself, she really doesn't have a clue what exactly I'm going through" (Mom 8). This sense of feeling different from partnered mothers and isolated is another source of stress for lone mothers.

Based on powerful pre-existing stereotypes, four participants spoke about how difficult it was for them to accept their new identity as single parents. One participant said, "there was some pain around being associated with that stereotype for me. I was also grieving the loss of that white picket fence fantasy; being around other families who have that made my loss more acute" (Mom 5). Another described a sense of shame, "…this is related to shame. I get that because of how I was raised. I'm the only one in my family who is single, it's not how I was brought up" (Mom 6). Mom 5 described it clearly:

> When I first became a single mom, I couldn't speak single mom without bursting into tears. I had such a strong perception of single moms as these loser people who messed up their lives. Why did they have their kids without a partner, anyways? I've carried that perception as what the rest of the world thinks, and I think quite a few people do.

Associating oneself with negative the stereotypes embedded in society compounds the stressful transition to independence for some of the study participants.

The interplay of poverty (experienced as material deprivation), inequality (experienced as powerlessness), and gender bias (experienced as role overload and negative stereotypes) exacerbated the stress level of participants in this study. It exacted a high price in terms of lone mothers' health or sense of balance. Participants sought relief from these conditions by accessing a peer support group.

The Perceived Impact of the Support Group on Lone Mothers' Health

Participants were asked to begin by telling their "story"; a reflection on how they became single mothers and how single motherhood influenced their well-being. Their stories were remarkably similar. Participants characterized their experience of finding themselves unexpectedly single and pregnant as traumatic. For example, Mom 2 described her decision to leave her partner as being "very scary" and "overwhelming". Mom 9 said she was shocked when her partner left. She said:

> We had a fight and he left for the weekend. And I (said), what's going on? And he (said) I'm not coming back. So it was a huge shock for me, the most shocking thing that happened in my life (Mom 9).

Many participants highlighted their feelings of powerlessness associated with the transition to lone motherhood. Mom 5 stated, "what had been happening in my life for the past 2 years was abusive and…um…not physically, but on an emotional level, and had become abusive on a financial level". Lacking control was also a common feeling associated with unexpected pregnancy for these participants. For example, Mom 8 said, "I felt like I didn't have any control over my body 'cause I was pregnant and I had this uncontrollable thing growing in me". The transition to lone motherhood was traumatic and left these participants feeling powerless.

Study participants made a connection with the local support group through recommendations from friends and professionals. Many of the participants had pre-existing relationships with other lone mothers through children's play groups and were encouraged to participate in the support group. For example, Mom 5 knew that she

needed to connect with other mothers and went to the support group after being referred from Transition House:

> I went looking when I left the Transition House and established a place to live and started the process…once I had settled a few things where I knew I could feed us and we had a bed to sleep in and we were safe, then I went looking. I'm….it was really important to me to establish some community because community is what holds me up in the best of times and is integral to not losing my mind in the hard times. So I can't remember where I first got a number or…I'm not sure, but I phoned and went to a potluck and another woman who had been in the Transition House with me came at the same time…it's even possible that she heard about it and just told me about it…and I think we went together and just kept going.

As a researcher, I am struck by this quote because it demonstrates tremendous insight into what she needed for support – community. Another participant shared a similar experience:

> I had known quite a few single moms um…when I was in a relationship and they were going to this group and they had talked about it and I had known about it because it's at the (project). And I've gone to this (project) which has been wonderful for me; the whole project alone has been great. I went there…my doctor's there, my midwife's there and I go to baby groups there. And so the group was there and I felt connected as a community going there (Mom 6).

In the next example, Mom 10 had seen other lone mothers benefit from coming together and she found this encouraging enough to seek it out:

> I think that I've seen people that have come from a difficult situation and been in the group and even not being in the group but hanging out with other lone mothers that has really benefited them, and they've come out doing really well, much better than they were in the beginning. So…I think. I think it might have given me the push to go um…and do it.

Some participants followed the example set by other lone mothers and sought out support. However, when some of the participants found themselves to be alone with their children, they seemed to know instinctively that they needed to reestablish a sense of community.

In response to the question, "how do you think the support group has influenced you?" participants consistently reported a positive experience of fun and friendship made possible by the provision of free services and child care. For example, one participant stated:

> The first meeting was a potluck. And um…and so the potlucks are very casual - you just …everyone brings food and you just sit around. And the kids are all together and they play and then you just sort of chit chat and stuff. And um they're all very, very friendly there. Um…and they make your feel um…they make you feel welcome (Mom 6).

Another participant described her first meeting with the single moms' group this way:

> …Some moms have their kids all day long forever, forever, all the time - with no breaks. And so when they go, they get like an hour and a half of like free child care which is big, and you get a little bit of food and you get to just sit and just

like say nothing or talk the whole time - your choice. You know? It is really a beneficial on the mother's health (Mom 8).

Participants began to attend the peer support group in pursuit of fun and friendship as antidotes to stress. The group was accessible and provided moms with prerequisites for participation, like child care. Some participants were referred to the group by friends or professionals, but others instinctively knew they needed to reach out to similar lone mothers.

Some study participants saw a direct link between the fun and friendship they experienced in the support group and the factors that influence their health. For example, one participant described:

> It was really fun because we were all on the same level, we were all there to get like our hair cut and to get pampered and there were treats and there was music and we were laughing and stuff. For one minute everyone was focused on having fun and forgetting that they were stressed or whatever (Mom 6).

Fun and friendship were antidotes to stress needed by the participants in this study. A few participants were able to articulate why it was important, or they were able to link fun and friendship directly to their health.

The bi-weekly pot luck suppers were consistently mentioned by the participants. As the researcher I wondered, "what is it about sharing food that the mothers find so rewarding?" Several participants provided me with an answer. Mom 2 said, "it's a cultural thing. Every culture has some celebration around food, socialization around food… I think it's more of a social thing, eating together and laughing". Mom 4 also supplied an answer to my question. She stated, "it (eating together) incorporates an

emotional aspect into it. You are doing it with intention, with the conscious intent to nourish whoever you are cooking for, you know, often it is your friends and family and um.. yourself - to share it". These participants were able to articulate a link between sharing food at the potluck dinners and their physical, emotional, mental, and spiritual health.

As their relationships with one another deepened over time, some participants identified a sense of connection binding participants to others with similar experience. Interpersonal connectedness fulfilled participants' need for a sense of belonging. When they spoke about their need to re-establish community, participants used phrases like, "hall of fame" (Mom 7) , "network of family" (Mom 8), "community" (Mom 5), and "tribe" (Mom 4) to describe their relationship to one another. Participants described a sense of being bound together by shared experience. One participant said, "I just connected with a lot of people there and I felt really good after because I felt like I was part of it like I was one of them, you know. I felt like I belonged, like I was normal" (Mom 9). Another participant said, "it's kind of like there's this membership thing, it's like a special, like wow, I'm a single mom and this is like my hall of fame kind of thing" (Mom 7). Their need to be connected to a larger community is fulfilled by membership in the support group.

This experience of belonging was thought to be specific to women. One participant described it as a "feminist quotient kind of thing" (Mom 7). The participants are bound together by a "higher level" of communication that often transcends words. For example, one participant said, "there's an understanding that we don't have with…like an unspoken understanding I think that's just there and we don't have to struggle with that"

(Mom 7). Connecting "woman to woman" was a unique bonding experience for the participants.

Several factors facilitated this experience of belonging, including sharing common experiences, accessing inspiring role models, positive collective energy, and having an opportunity to vent or debrief. For example, Mom 4 explained why she feels connected to the group:

> …Shared experience and recognition that we're at the same place, that we're peers. That there's not that power over you…we're dealing with the same stuff. We're dealing with trying to raise kids without money, without dads, without grandparents.

Many of the participants said they felt a deeper level of connection to the group because the support group is made up of mothers who have similar characteristics and similar experiences. Some participants said that role models from the group promote cohesiveness because their stories inform and inspire other mothers. For example, one participant said she felt inspired by "hearing other people's stories and listening to women who once were…in a similar situation and made it and are successful women and successful mothers and have raised successful families" (Mom 3). Participants said things like, "it was a safe place to experience my life out loud" (Mom 5), and "it's a place I feel safe where we could work on our separation anxiety with each other in a safe environment" (Mom 8). The participants were just as clear about the importance of being heard and understood. They made statements like, "when I go there, I feel understood. Things that have become important to me, I am able to speak about and have a conversation about" (Mom 5), and "I think they understand where I'm coming from"

(Mom 8). The participants who felt connected to this group were able to identify several factors that made this cohesiveness possible.

Not all participants felt equally connected, however. In fact, participants who felt less connected to the group were able to cite specific factors that, at times, contributed to a sense of disconnection including stereotype influences, a need for anonymity, facilitator's influence, feeling out of synch with the rest of the groups' healing journey, and not sharing some significant experiences. For example, one participant said:

> The difference is that in that group, a lot of the mothers are on social assistance and I am not on social assistance. And the one's that are not on social assistance, there's a few of them and they are going back to school to do post-secondary education and all sorts of different things. And so they have student loans and a low-income as well. And um…that's not to say that my income is like through the roof, but I have the potential. I work part-time now and I have the potential to make good…good money. I have a profession, um and so that sort of sets me apart from everybody else (Mom 6).

By not personally experiencing the influence of the social welfare system, this participant had limited ability to identify with other mothers' experiences and it set her apart from the group. All of the participants felt varying degrees of connection with the group over time, however a few participants lacked experience in some momentous situations that helped to bring other mothers together in solidarity.

Every participant who felt strongly connected to the group was able to identify some combination of factors contributing to this cohesiveness, including sharing common experiences, accessing inspiring role models, positive collective energy, and having an

opportunity to vent or debrief. The social support group fulfilled a number of the participant's mental, emotional, and physical needs, but primarily it fulfilled the spiritual need to connect with a community of other similar women.

The lone mothers' support group embodied a collective female energy that the participants felt could only be found by connecting "woman to woman". For example, one participant said:

> I don't know if it's just a combination like if it's just all of us being in the same room, the energy just all combined together because it's not even necessarily what people are saying really it's just because like I said I don't really need to go and unload or say anything it's just being in the same room as all of these women (Mom 10).

The collective force and sense of solidarity within the group created new positive energy.

I asked some of the participants to explain how being connected to a community of other similar women improves their health. They told me feeling connected to other lone mothers helped to uplift them and gave them the strength to move forward. One participant described it this way:

> When I go to the single moms and see this array of amazing, strong, beautiful, growing, women who can do things and balance things and still be there for other people and their children and, I guess I take a piece of that and feel honored to be included in that group of people… and that is huge for me. I think that is what fills my cup. I walk away thinking if I can be a part of that, then maybe I am freakin' amazing! (Mom 5).

Another participant said:

> It just brings positivity back into my life and realization that I can keep going and, I don't know, it just sort of gives me a kick start again… I never really thought of it before but I'm starting to think about it now and I see myself as a different person and I know physically that I haven't changed much but I just see myself as a completely different person then I used to be (Mom 10).

Joining the peer support group to relieve stress and reconnect with a community of similar other women seemed to be transformative.

Connecting to the tribe of other similar women was described as a spiritual experience culminating in an increased ability to take control, make decisions, and set new boundaries in relationships. For example, several participants talked about how they can now incorporate their ex-partners into their lives as the fathers of their children. Mom 2 said:

> I am very clear with him…like almost…like all the time….constantly even if I don't need to be. 'Cause I just want it to be very clear and don't want him to have any inkling in his mind that there can be anything between us ever again.

Another participant described it this way:

> As you're going through these dramatic changes in your life, you're learning and growing…and I was learning how to set my own boundaries...When I'm out there in the world, I am able to ask for what I need, respect when other people ask for what they need, and make a decision to give or not give based on where I'm at and not take it personally when someone is angry at me for my decisions because I now understand that it has nothing to do with me - it's them! (Mom 5).

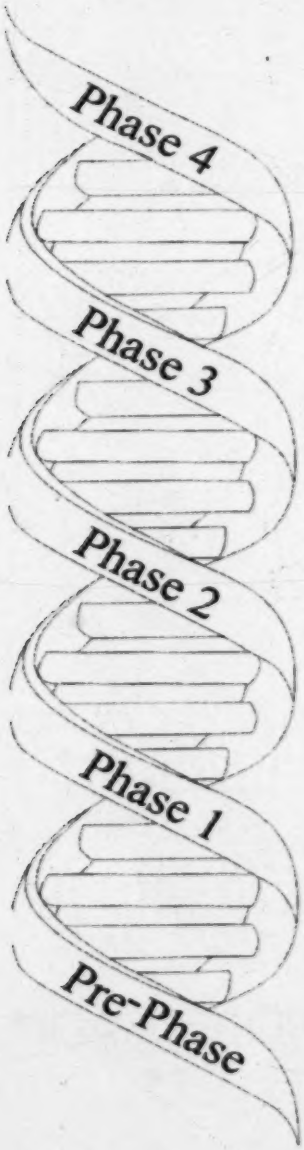
Participants described feeling uplifted, strong, and in control of their lives. They said they felt transformed into empowered women who, for the first time, were able to set important relationship boundaries on their own terms. For example, some participants were able to reincorporate their ex-partners into their lives in a new, healthy way. This transformation was marked by an internal locus of control, improved self perception and self efficacy. For many of the participants, the process resulted in an ability to transcend the limitations and barriers of lone motherhood.

This journey towards inner strength has been labeled *Transcending Lone Motherhood.* Reducing Stress, Re-establishing Community, Re-energizing, and Moving Forward are the four phases of Transcending Lone Motherhood as described by the participants in this study. Transcending Lone Motherhood is represented heuristically in Figure 2.0.

Transcending Lone Motherhood is a spiritual process motivated by a traumatic disruption in life expectations, such as an unplanned pregnancy or the breakdown of a significant relationship. Participants in this study described a sense of shock, lack of control, and uncertainty followed by a need to make sense of what happened; a need to figure out how to carry on. I consider this a pre-phase because it motivated participants to seek out support from their peer group and begin the process of rising beyond to cope with the negative aspects associated with lone motherhood.

Phase 1 of the process is called *Seeking Stress Reduction*. Phase 1 commenced when participants began to attend the peer support group in pursuit of fun and friendship as antidotes to stress. Some participants were referred to the group by friends or

Figure 2.0. The Process of Transcending Lone Motherhood



Phase 4:
Moving Forward
-uplifted, strong and in control.

Phase 3:
Re-Energizing
-deep woman to woman bond.
-Sense of solidarity.

Phase 2:
Re-establishing Community
-develop sense of connection.

Phase 1:
Seeking Stress Reduction
-seeking fun & friendship.
-facilitated by food & free child care

Pre-Phase:
Traumatic Change to Expectations
-related to separation from partner
or unplanned pregnancy.

professionals, but others instinctively knew they needed to reach out to similar lone mothers. Relief from stress was facilitated by the provision of free child care services and enhanced by the provision of food and fun activities. Participation in the peer support group helped to meet lone mothers' immediate need for stress relief.

Phase 2 of the process is *Re-establishing Community*. It is characterized by the development of a sense of connection, binding participants to others with similar experience. Interpersonal connectedness fulfilled participants' need for a sense of belonging. Progression towards phase 2 of the process was facilitated by several factors including a sense of safety, sharing common experiences, and feeling validated, heard and understood.

Phase 3 is called *Re-energizing* because the collective force from the group created new positive energy. Phase 3 is characterized by development of the capacity for unspoken understanding that was thought to be specific to women; one woman referred to it as the "feminist quotient". Participants experienced a sense of solidarity in this phase.

This process culminated in the final phase, called *Moving Forward*. Participants described feeling uplifted, strong, and in control of their lives. They said they felt transformed into empowered women who, for the first time, were able to set important relationship boundaries on their own terms. For many of the participants, the process resulted in an ability to transcend the limitations of lone motherhood and regain a sense of balance in their lives.

Summary of Findings

Health was defined by the participants in this study as a sense of balance. They noted the interrelationship between mental, physical, emotional, and spiritual well-being. Participants were able to provide several examples of the interplay between these aspects of health in their daily lives, like poverty and stress.

When participants discussed the impact of lone motherhood upon their health several social structures and conditions were identified. For example, they described how poverty, isolation, coming to terms with a new identity often associated with a negative stereotype, and fatigue secondary to the burden of fulfilling multiple roles created an inordinate amount of stress for these participants. The social welfare system also seemed to exacerbate stress for participants who depended on it for financial support. Participants identified stress as the most significant factor affecting their health. The situational stress of being a single mother was exacerbated by poverty, inequality, and gender bias, resulting in a compromised capacity to cope.

Participants came to the peer support group seeking fun, friendship, and stress relief. Many of them embarked on a spiritual journey that began with finding a connection to a community of like-minded individuals. A sense of belonging developed which led to renewed energy and climaxed with a sense of increased strength and the power to move forward in life. This journey has been named "Transcending Lone Motherhood" and it is the basic social process underpinning this peer support experience.

Chapter 5 – Discussion

Transcending Lone Motherhood in the Context of Other Grounded Theory Studies Involving Women

As I researcher, I wondered if the process of *Transcending Lone Motherhood* had been documented in other studies. The health and social sciences literature was reviewed focusing on grounded theory studies involving women. One grounded theory study of lone mothers was evaluated (Hertz & Ferguson, 1998). Hertz & Ferguson (1998) identified strategies used to overcome lone mothers' financial challenges including the development of connected relationships with friends and family. Connectedness to others is a characteristic of phase 2 "Reestablishing Community" in Transcending Lone Motherhood.

Three studies related to women with terminal cancer are similar to Transcending Lone Motherhood (Halstead & Hull, 2001; Landmark e al, 2001; Thomas & Retsas, 1999). For example, Halstead & Hull (2001) explored the process of spiritual development in women with cancer. The basic social process, referred to as "Struggling with Paradoxes", began when the women were diagnosed. The first phase was characterized as a need to find meaning, similar to the pre-phase of Transcending Lone Motherhood. The second phase of Halstead & Hull's (2001) process involved connecting with others which was thought to be an important factor in the women's spiritual growth, comparable to this study's second phase "Reestablishing Community".

Landmark et al (2001) conducted a grounded theory study of women living with breast cancer. A core category emerged as "The Will to Live", mobilized by the trauma

associated with changed life expectations after diagnosis. Although phases of this process were not recognized, coping strategies were identified including the women's need to find plausible explanations and make meaning from their experience. This is similar to the participants' need to make sense of what happened in the pre-phase of Transcending Lone Motherhood.

Thomas & Retsas (1999) conducted a grounded theory study of the spiritual dimensions of people with terminal cancer. The basic social process identified in their study was called "Transacting Self Preservation" and described as a spiritual journey. The first stage of their process was called "Taking it all In". This phase was described similarly to the pre-phase noted in Transcending Lone Motherhood because participants experienced trauma and shock. Participants described a need to make sense of what was happening, similar to this study. Connecting with others was identified as a coping strategy utilized in Thomas & Retsas' second stage called "Getting on with Things". The need to connect with others is similar to "Reestablishing Community" in this study. Thomas & Retsas' final stage is called "Putting it all Together" and it is characterized as transcending, transforming, and expanding consciousness, similar to the final phase of Transcending Lone Motherhood.

Two other grounded theory studies (within which a specific process was not necessarily identified) yielded similar characteristics to Transcending Lone Motherhood. For example, Bowes, Tamlyn, & Butler (2002) conducted a study of women with ovarian cancer. Their research yielded a number of action strategies useful in coping with terminal illness including sharing experiences to create a bond with others (similar to phase 2 of Transcending Lone Motherhood), and searching for meaningful information

(similar to pre-phase of Transcending Lone Motherhood). Interactional strategies included sharing emotions similar to the emotions expressed by participants in this study, such as crying, laughing, and expressing anger (venting or debriefing in Transcending Lone Motherhood).

Craft (1999) conducted a study of women coping with breast cancer to build a conceptual model of female hardiness. Although a specific underlying process was not identified, participants described a strong sense of purpose and deepened relationships with friends in order to develop inner strength. In comparison, the participants in Transcending Lone Motherhood viewed their health as a resource for parenting, connected with similar others, and perceived the outcome of the process to be increased strength.

Transcending Lone Motherhood is similar to the processes or characteristics identified in all five grounded theory studies of women's experiences with terminal cancer in three respects: A traumatic experience changing life expectations was the precursor for a spiritual journey to find meaning, the process or experience involved connected relationships with others, and the process or experience resulted in increased inner strength or life satisfaction.

Transcending Lone Motherhood was different from the cancer studies in that the cancer studies mentioned a connection to god or religion, but participants in the lone motherhood study did not. Participants in the lone motherhood study described a need to seek relief from stress (phase 1 of Transcending Lone Motherhood), whereas participants in the other studies did not. The Re-energizing phase of Transcending Lone Motherhood was also not described in the cancer studies.

In contrast to the grounded theory studies of women's experiences with terminal illness, two grounded theory studies of women's experiences with chronic illness were explored for commonalities (Asbring, 2001; Schreiber, 2001). Schreiber (2001) examined women's experiences with chronic depression, and Asbring (2001) studied women's experiences with chronic fatigue syndrome. Both studies identified themes similar to those found in Transcending Lone Motherhood including a disruption in the expected life course with the onset of disease, a search for meaning, and changed relationships with significant others. Both studies identified the process to be transformative. The study by Asbring (2001) identified the outcome to be transcendence from illness, increased personal integrity, and self respect, similar to Transcending Lone Motherhood.

Three grounded theory studies of women caregivers were reviewed for comparison to Transcending Lone Motherhood (Jones, Zhang, & Meleis, 2003; Wuest, Ericson, & Stern, 2001; Wuest, 2001). Jones et al (2003) studied the experiences of immigrant women in the caregiving role. Women caregivers seemed to experience conditions similar to lone motherhood, such as role overload, fatigue, stress, and compromised well-being. The transformative process was characterized by connectedness with significant others and resulted in an increased sense of strength and competence, similar to Transcending Lone Motherhood. Wuest et al (2001) examined the impact of support on caregivers. "Holding On" was the basic social process characterized by gaining control, draining resources, and jeopardizing relationships. Connectedness with others played a significant role in gaining control, however other similarities to Transcending Lone Motherhood were not noted. Wuest's (2001) study of women caregivers identified a basic social process called "Precarious Ordering". The phases of

this process are quite different from Transcending Lone Motherhood, however re-establishing boundaries and relationships with others was recognized as a strategy in the second phase of the process. In addition, the role of religious connectedness was identified in two studies of caregivers, but not noted in this study of lone mothers.

The social processes identified in two grounded theory studies of women's responses to violence were compared to this lone motherhood study for similarities (Drauker & Stern, 2000; Wuest & Merritt-Gray, 2001). In Draucker & Stern (2000) women viewed their experience with abuse as a traumatic disruption of their lives, similar to the experience of becoming a lone mother in this study. The process of "Getting Back on Track" in the Draucker & Stern (2000) study involved sharing experiences with others in order to feel validated and reassured, similar to the need to find other lone mothers with similar experiences in this study. The abused women sought explanations for their experiences and found inner strength in the process, comparable to the outcome in Transcending Lone Motherhood. Wuest & Merritt-Gray (2001) found that the process of "Reclaiming Self" after leaving an abusive partner began after participants experienced trauma, the process was grounded in social connections, and increased strength and capability were outcomes of the process, similar to Transcending Lone Motherhood.

Thirteen grounded theory studies of women's experiences with lone motherhood, terminal cancer, chronic illness, a new caregiver role, and recovery from abuse were reviewed and compared to the process described in this study of lone mothers. Some of these studies were distinctively different from this study. For example, the role of religious connectedness was not identified in this study, but was described in several of the other women's studies. Renewed energy was identified as a distinct phase in the

process of Transcending Lone Motherhood, however it was not recognized in any of the other studies. There were some noteworthy similarities between the studies including the experience of trauma as a catalyst to engage in the process or journey (noted in ten of the studies), the central role of social connectedness in the process or experience (noted in 11 of the studies), and the development of inner strength (noted in five of the studies) and the ability to move forward in life as an outcome of the experience or process. All of these studies concern the transformation of interpersonal relationships.

Transcending Lone Motherhood in the Context of Other Scholarly Literature

Participants in this study of lone mothers' peer support repeatedly identified "sense of connection" to be a fundamental aspect of the process of Transcending Lone Motherhood. According to Chiu, Emblen, Hofwegen, Sawatzky, & Meyerhoff (2004), interpersonal connectedness is a common theme found in the literature related to spirituality. Lauver (2000) conducted a review of the literature specifically related to women's spirituality and found that in women's spirituality groups, women co-participate in creating sacred space and rituals with others. Burkhardt (1994), and Dyson, Cobb, & Forman (1997) also believe that spirituality is manifested through connecting relationships with others.

Social connectedness has also been explored in recent research from psychology, nursing, and health promotion. For example, Lee, Keough, & Sexton (2002) describe social connectedness as "an enduring and ubiquitous sense of interpersonal closeness with the social world" (p. 355). The women in Shields' (1995) study describe social connectedness as a relational sense of commitment to other women in the community.

Health promotion research also recognizes the importance of interpersonal relationships, sense of community, and the influence of supportive networks. For example, Cadell, Karabanow, & Sanchez (2001) identify relationships with close others as a stress buffering factor. Minkler & Wallerstein (1997) emphasize social action by connecting with similar others and they refer to this process as community organizing and community building. Work from the Centre of Health Promotion at the University of Toronto recognizes social connectedness as a quality of life dimension (Raphael, Steinmetz, Renwick, Rootman, Brown, Sehdev, Phillips, & Smith, 1999). The construct "sense of connection" emerging from this study is similar to social connectedness explored in the nursing, psychology, and health promotion literature.

Re-energizing was a distinctive phase in Transcending Lone Motherhood. The effects of power, force, or energy are also discussed in one review of the literature related to spirituality and one study of women's spirituality (Burkhardt, 1994; Chiu et al, 2004). Burkhardt (1994) described spirituality as a unifying force. Chiu et al (2004) described spirituality as a coalescing force, a creative energy, a unifying force, and an integrative energy. The power perceived by the participants in the lone motherhood study is similar to the spiritual energy discussed in this literature review and study.

The final phase of Transcending Lone Motherhood culminates in increased inner strength and a renewed sense of self efficacy and self esteem. Participants felt uplifted and able to move forward in their lives with a positive outlook. This transformation serves as a resource for overcoming life's obstacles. Participants' description of this journey is similar to several authors' descriptions of a spiritual journey. For example, Tanyi (2002) believed that spirituality results in an ability to transcend beyond the

infirmities of existence. McSherry & Draper (1998) held that spirituality enables us to transcend the natural realms and limitations of our existence. Chiu et al (2004) contended that spirituality involves expanding beyond the limits imposed by the immediate situation.

Transcending Lone Motherhood and Health

Participants from this study reported that the process of Transcending Lone Motherhood contributed to improved health and well-being. They defined health as a sense of balance and noted the interrelationship of the physical, mental, emotional, and spiritual aspects of health. The participants' definition of health is consistent with a health promotion perspective which conceptualizes health in terms of the meanings we create from our own experience (Labonte, 1993). Health promotion discourse refers to health holistically and as a resource for everyday living, similar to the view shared by women from this study (Breslow, 1999; Kickbusch, 2002; Nutbeam, 1998).

For comparison, I reviewed the definition of health from one article published in each of the following: A women's health journal, a psychology journal, a medical journal, a health promotion journal, and a nursing journal. All of the journals were peer-reviewed. The health promotion article defined health as "a resource for everyday life, not the object of living. It is a positive concept emphasizing social and personal resources as well as physical capabilities" (Nutbeam, 1998, p. 351). According to Nutbeam (1998) health promotion definitions of health recognize the link between social and economic conditions, physical environments, and lifestyle factors. A holistic view of health is understood in health promotion discourse. The nursing article reflected a definition of

health similar to the definition articulated by the participants' from this study (Saylor, 2004). Saylor (2004) conducted an extensive review of the health sciences literature to formulate a health definition model. The author proposes a "Circle of Health" to reflect physical (body) and non-physical (mind and spirit) dimensions of health, similar to the way some aboriginal Canadians' view health (Turton, 1997). This circle model also represents balance and energy, renewal, and recovery. Similarly, the article from the women's health journal defined health as a balance between mind, body, and spirit (Canales, 2004). From a counseling psychology perspective, Cohen (1998) also described women's health as emotional, social, spiritual, cultural, and physical well-being influenced by social, political, and economic factors. In contrast, the editorial by Curtis (2003) from the medical journal highlighted the biomedical perspective as the prevailing view of women's health in medicine. However, it also advocated for a broader, more socially, politically, and economically inclusive definition (Curtis, 2003). This cursory review of the literature from nursing, women's health, health promotion, and psychology demonstrated consistency between definitions of health, reflecting a holistic, contextual perspective. The definition of health from the medical journal was limited to a biomedical perspective, but noted the need to move towards a definition that reflects the reality of women's everyday lives.

Limitations and Implications for Practice and Research

Findings from this study were used to generate substantive theory to explicate the basic social process underpinning the influence of peer support on lone mothers' health. Results may be generalized to other peer support programs for similar lone mothers.

However, this model must be further clarified through research with diverse groups of women and differentiated in practice.

Further research should endeavor to better reflect a feminist perspective by incorporating a participatory approach into the research process. Integrating a participatory approach like collaborative analysis, may address power differentials that inherently exist in the interviewer-participant relationship (Kushner & Morrow, 2003). For example, the interviews in this study were focused by specific questions influencing the direction of the discussion. Alternatively, interview questions could be generated from focus group results. The women would be able to direct the course of the conversation towards issues they feel are salient to the discussion. Control over the research process would be shared and more consistent with a feminist perspective.

In addition, opportunities for participation may stimulate more social action associated with the research process. For example, some women in this support group have the potential to mentor new lone mothers, facilitating the process. I plan to disseminate information from this study by seeking publication in a scholarly journal and by presenting my findings at a national conference. Participants from this study will also be invited to put forward a proposal to present study findings in the form of a dramatization at the upcoming International Family Nursing Conference. Opportunities for participation stimulate social action and reflect the critical feminist perspective assumed at the beginning of this research process.

The findings from this study have implications for health promotion practice. They inform our understanding of the interplay of social determinants of lone mothers' health such as poverty, inequality, and reduced ability to cope due to increased stress.

This information may help us to develop support programs and policies that are more responsive to the needs of lone mothers. Social welfare policies should be examined for their detrimental effects on lone mothers' mental health and well-being. For example, social assistance benefits currently provide an inadequate allowance for lone mothers requiring two bedroom accommodations in low vacancy rate locations, forcing mothers to use money budgeted for groceries to pay their rent. Social services employees should be educated to deliver programs and services in a way that is respectful of consumers.

This study provided an intimate look at the context of lone mothers' lives from their point of view. An opportunity to look at the problem through a different lens has the potential to positively influence public service agencies' policies and practice. According to Wuest et al (2002):

> The research process contributes to shaping services in minor ways and raising consciousness among policymakers regarding how their work plays out in women's everyday lives. The dialogue raises questions about taken-for-granted practices and assumptions with the potential consequence of changing how specific issues are viewed (p. 806).

Finally, this study helps us to recognize that health promotion programs for groups of vulnerable women should be evaluated for their potential to be transformative; to help women transcend the limits of their situation to achieve a sense of well-being.

Conclusion

A grounded theory study of 10 lone mothers from a local peer support group was conducted in order to address the interplay between social structures and conditions and

lone mothers' health. Specifically, the study sought to illuminate our understanding of the interaction of the social determinants of lone mothers' health, and the basic social process underlying social support's impact on health.

Findings from this study suggest that lone mothers define health as the interaction of mental, physical, emotional, and spiritual aspects of well-being, experienced under optimal circumstances as a sense of balance. Stress had a strong influence on participants' sense of balance. Relative poverty, isolation, negative stereotypes, fatigue, and social welfare policies and practices exacerbated their level of stress, affecting their health by compromising their ability to cope.

Lone mothers joined a peer support group and some began a spiritual journey called "Transcending Lone Motherhood". It is a four-phase process motivated by the traumatic experience of finding oneself pregnant, alone, and searching for meaning. Phase 1 involved the search for fun and friendship in order to relieve stress. In phase 2 participants developed a sense of connection to a community of similar lone mothers. A sense of belonging developed which led to renewed energy in phase 3. Phase 4 of the process culminated with a sense of increased strength and the power to move forward in life. The four phased process of Transcending Lone Motherhood was the basic social process underpinning the influence of peer support on lone mothers' health.

After further clarification and refinement, a heuristic model of this process may be useful for guiding health and social policy development and practice. It may help practitioners and policy makers view the problems of single parenthood from lone mothers' perspectives. This study also helps to inform health promotion practitioners of

the transformative power of peer support and lone mothers' potential to transcend their situation to achieve a sense of well-being.

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Appendix A

Information Letter

Project Title:	Peer Support and Social Determinants of Lone Mothers' Health
Principal Investigator:	Marilyn Plummer R.N., B.S.N., M.Sc. Candidate Centre for Health Promotion Studies, University of Alberta
Supervisors:	Dr. Lynne Young, Adjunct Professor Dr. Helen Madill, Professor and Graduate Programs Coordinator Centre for Health Promotion Studies, University of Alberta

Information:

I would like to invite you to participate in a research project that I am conducting as a requirement of the Master of Science in Health Promotion Program at the University of Alberta.

The purpose of the research is to look at how peer support influences lone mother's health. This information may be beneficial to people who plan programs or influence policies that affect the everyday lives of lone mothers. It may also help you think about your health in a new way.

Information will be collected from the following sources:

- Audiotaped individual interviews which will be transcribed verbatim;

The researcher will respect the participant's right to confidentiality by applying the following strategies:

- The information you provide will be kept for at least 5 years after the study is done. The information will be kept in a secure area (ie- locked filing cabinet).
- After 5 years, paper files will be shredded and audiotapes and electronic files erased.
- Your name or any other identifying information will not be attached to the information you gave. Your name or the name of the support group will also never be used in any presentations or publications of the study results.
- Ensuring that the research process is in compliance with the University of Alberta Ethical Guidelines for Research Involving Human Participants.

The participant has the right to withdraw from the research process or refuse to answer a question at any time without explanation and without penalty.

To cover possible incidental expenses that you might have related to your participation, like transportation and child care expenses, you will be paid an honorarium of $25.00. In addition, you have my deep appreciation; my research project would not have been possible without your support.

Appendix B

Consent Form

Consent of Subject:

Do you understand that you have been asked to be in a research study?	Yes	No
Have you read and received a copy of the attached information sheet?	Yes	No
Do you understand the benefits and risks involved in taking part in this research study?	Yes	No
Have you had a chance to ask questions and discuss the study?	Yes	No
Do you understand that you are free to refuse to participate or withdraw from the study at any time? You do not have to give a reason and it will not affect your health care.	Yes	No
Has the issue of confidentiality (privacy) been explained to you? Do you understand who will have access to your information?	Yes	No

Signatures:

This study was explained to me by:_____

Date: _____

I agree to take part in this study

_____ _____

(signature of participant) (print name)

_____

(witness)

_____

(date)

Questions about the risk to you as a participant in this study may be directed to:

Appendix C

Interview questions

1. What does it mean to you to be healthy?

2. How has your experience of being a lone mother influenced your health?

3. Tell me about your experiences of support provided by other lone mothers?

4. How has support from peers affected your health?

5. If necessary, I will probe for specific information about peer support and its influence on the mother's life using "how" and "why" questions.

6. What are the qualities you look for in a support person?

7. Tell me about a time when you received support and it was challenging for you and the person offering support.

8. What are your experiences receiving support from professionals, like nurses, social workers, etc.?